STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E210	A. BUILDING _____ B. WING _____	03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW MANOR OF PEABODY	**500 PEABODY PEABODY, KS 66866**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #83733.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 156	Continued From page 1 The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to	F 156		

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F 156	Continued From page 2 receive refunds for previous payments covered by such benefits. This Requirement is not met as evidenced by: The facility had a census of 50 residents. The sample included 14 residents. Based on observations and interview the facility failed to post the names, addresses, and telephone numbers of the pertinent state survey and certification agencies with a statement that the resident may file a complaint with the state agencies about the cares he/she received for the 50 residents who resided in the facility. Findings Included: - On 3/19/15 at 0920 AM, observation revealed the bulletin board utiized for resident information lacked the state agency contact information for complaints or concerns by residents or the public. On 3/18/15 at 2:45 PM, Resident #30 stated he/she lacked knowledge on how to contact the appropriate state agencies for complaints about the care he/she received. On 3/19/15 at 10:41 AM, Resident #47 stated he/she lacked knowledge on how to contact the appropriate state agencies for complaints about the care he/she received. On 3/18/15 at 2:10 PM, Resident #54 stated he/she lacked knowledge on how to contact the appropriate state agencies for complaints about the care he/she received.	F 156		

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F 156	Continued From page 3 On 3/18/15 at 2:14 PM, Resident #32 stated he/she lacked knowledge on how to contact the appropriate state agencies for complaints about the care he/she received. On 3/18/15 at 9:27 AM, Social Service Staff G verified the facility did not have the state agencies contact information posted for the residents. He/she stated the mental health facility did not have an Ombudsman for a resident advocate. On 3/19/15 at 2:35 PM, Administrative Staff A verified the facility did not have the state agencies contact information posted for residents. Administrative Staff A placed a printed copy of the state agency contact numbers on the bulletin board located by the Director of Nursing's office, on 3/19/15, following the discussion. Although requested, the facility did not provide a policy and procedure on posting the state agency contact information for resident use to voice complaints on abuse, neglect, misappropriation of funds, or non-compliance with advance directives. The facility failed to post the names, addresses, and telephone numbers of the pertinent state survey and certification agencies with a statement that the resident may file a complaint with the state agencies about the cares he/she received, for the 50 residents who resided in the facility.	F 156		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.	F 167		

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F 167	Continued From page 4 The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This Requirement is not met as evidenced by: The facility had a census of 50 residents. The sample included 14 residents. Based on observations, record review, and interview the facility failed to have the most recent survey, available for examination, in a place readily accessible for the 50 residents who reside in the facility. Findings Included: - On 3/18/15 at 2:45 PM, Resident #30 stated he/she was of unaware where the most recent survey results were located and the location had not been discussed at the resident council meetings. On 3/18/15 at 9:27 AM, Social Service Staff G stated the most recent survey results were kept in the administration office and not available after hours for the residents to view. On 3/19/15 at 2:35 PM, Administrative Staff A stated the most recent survey results were not readily accessible to the residents because in the past the residents had ripped the pages up. Administrative Staff A stated a different arrangement could be made to have the survey results available to the residents. Although requested, the facility did not provide a policy and procedure for placement and accessibility of the current year's survey.	F 167		

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F 167	Continued From page 5 The facility failed to place the most recent survey results in a location readily accessible to the 50 residents who reside in the facility.	F 167		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This Requirement is not met as evidenced by: The facility had a census of 50 residents. Based on record review and interview the facility failed to provide written evidence that the facility conducted criminal background checks on the pre-screening of 2 of 5 employees reviewed. (#I, #J) Findings Included: - On 3/18/15 at 11:25 AM, Administrative Staff H stated the facility previously retained a printed copy of the background checks in the employee personnel files. He/she stated since the facility began verifying the background checks on the internet, the report was only printed and retained if a problem was identified. On 3/19/15 at 2:35PM, Administrative Staff A verified the facility did not have written verification of #I and #J's background checks in his/her personnel files. The facility's 10/01/01 Criminal Background Checks policy and procedure stated:	F 226		

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F 226	Continued From page 6 *The facility must institute a further criminal record check on all applicants for employment by contacting local law enforcement authorities, state registries or repositories, and/or state and national clearinghouses. *The results of all criminal background investigations are confidential, must be filed in the employee's medical/confidential file, unless otherwise required by state law, and must be retained in a secure location in accordance with company policy regarding personnel files. The facility failed to provide written evidence that the facility conducted criminal background checks on the pre-screening of 2 employees (#I, #J) as outlined in the facility's Criminal Background Checks policy.	F 226		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329		

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F 329	Continued From page 7 drugs. This Requirement is not met as evidenced by: The facility had a census of 50 residents. The sample included 14 residents, of which 5 were reviewed for medication regimen. Based on observation, interview and record review the facility failed to ensure the drug regimen was free of unnecessary drugs for 2 of 5 residents sampled, who received scheduled Tylenol. (#7, #36) Findings included: - Resident #7's annual (MDS) Minimum Data Set assessment, dated 11/10/14, indicated the resident alert and oriented with a (BIMS) Brief Interview for Mental Status score of 15, and independent to limited assistance with (ADLs) Activities of Daily Living. The MDS indicated the resident received scheduled pain medications, reported no pain, and received antipsychotic, antidepressive and diuretic medications 7 days of the look back period. The quarterly MDS, dated 2/8/15, indicated the same. The 11/11/14 (CAA) Care Area Assessment summary for medication use directed the staff to administer medications as ordered, educate the resident of the risks of refusing medication, observe for oversedation, and notify the physician if needed. The 2/16/15 care plan directed the staff to administer medications as ordered, educate the resident of the risks of refusing medication,	F 329		

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F 329	Continued From page 8 observe for oversedation, and notify the physician if needed. The 3/5/15 physician's order sheet directed the staff to administer Tylenol, 1000 (mg) milligrams, 4 times daily, to the resident, initiated 9/25/07. The 3/17/15 pharmacist consultant document recommended a dose reduction or risk versus benefit statement for the continued use of 4000 mg of Tylenol, daily. Review of the monthly pharmacist recommendations to the Director of Nursing for the past 15 months, revealed no concerns regarding the amount of Tylenol the resident received (4000 mg, daily) until 3/17/15, when he/she recommended a dose reduction. On 3/18/15 at 11:55 AM, the resident stood patiently in line for his/her medication, took medications with water and had no problems. On 3/19/15 at 8:50 AM, Nurse G stated the resident does not complain of pain. Nurse G stated he/she had not been aware of any dosage limitations for Tylenol until the pharmacist was here 2 days ago and recommended a decrease in the resident's dosage. Nurse G stated the physician had ordered the decrease. On 3/17/15 at 3:55 PM, Administrative Nurse B stated the resident has received Tylenol, 4000 mg, daily, for a long time. He/she verified the resident's physician had not changed the dosage of Tylenol since 2007. The (FDA) Food and Drug Administration web site, fda.gov, stated manufacturers must use specific language referring to Tylenol's maximum dosage in term of dosage units, or total number of tablets that should not be exceeded in a 24	F 329		

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hour period. The FDA stated the label had to read "Severe liver damage may occur if you take more than 8 (500 mg) tablets, for a total of 4000 mg, in 24 hours, which is the maximum daily amount for Tylenol.

The facility failed to evaluate Resident #7's continued maximum dosage of Tylenol, putting the resident at risk for liver damage from the excessive, long term dosage.

- Resident #36's annual (MDS) Minimum Data Set assessment, dated 10/20/14, indicated the resident alert and oriented with a (BIMS) Brief Interview for Mental Status score of 15, and independent with (ADLs) Activities of Daily Living. The MDS indicated the resident received scheduled pain medications, reported no pain and received antipsychotic, antianxiety, antidepressive and diuretic medications 7 days of the look back period. The quarterly MDS, dated 1/18/15, indicated the same except frequent moderate pain.

The 10/20/14 (CAA) Care Area Assessment summary for medication indicated nursing to administer medications as ordered and observe for oversedation.

The 1/26/15 care plan for pain directed staff to encourage the resident to describe his/her pain and location, administer medications as ordered, evaluate effectiveness of pain medications, and notify the physician as needed.

The 3/5/15 physician's orders directed staff to administer Tylenol, 1000 (mg) milligrams, 4 times daily to the resident, (initiated 10/12/10).

The 1/27/15 physician's note stated the resident's

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F 329	Continued From page 10 pain in his/her hip was well controlled and the resident was managing well with scheduled Tylenol. Review of the monthly pharmacist recommendations to the Director of Nursing for the past 15 months, revealed no concerns regarding the amount of Tylenol the resident received (4000 mg, daily) until 3/17/15, when he/she recommended a dose reduction. The 3/17/15 pharmacist consultant document recommended a dose reduction or risk versus benefit statement for the continued use of 4000 mg of Tylenol, daily. On 3/18/15 at 11:01 AM, observation revealed the resident took his/her medications and stretched his/her neck upward while swallowing. On 3/19/15 at 8:50 AM, Nurse G stated the resident does not complain of pain. Nurse G stated he/she had not been aware of any dosage limitations for Tylenol until the pharmacist was here 2 days ago and recommended a decrease in the resident's dosage. Nurse G stated the physician had ordered a dose reduction. On 3/17/15 at 3:55 PM, Administrative Nurse B stated the resident had received Tylenol, 4000 mg, daily, for a long time. He/she verified the resident's physician had not changed the dosage of Tylenol since 2010. The (FDA) Food and Drug Administration web site, fda.gov, stated currently manufacturers must use specific language referring to Tylenol's maximum dosage in term of dosage units, or total number of tablets that should not be exceeded in a 24 hour period. The FDA stated the label had to	F 329		

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F 329	Continued From page 11 read "Severe liver damage may occur if you take more than 8 (500 mg) tablets, for a total of 4000 mg, in 24 hours, which is the maximum daily amount for Tylenol. The facility failed to evaluate Resident #36's continued maximum dosage of Tylenol, putting the resident at risk for liver damage from the excessive, long term dosage.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility reported a census of 50 residents. Based on observation, record review and interview the facility failed to ensure the ice machine in the facility's kitchen had a 2 inch air gap in the drain line. Findings included: - On 3/19/15 at 10:30 AM, observation in the facility kitchen revealed the ice machine drain pipe rested inside the floor drain, touching the heavily soiled side of the floor drain. On 3/19/15 at 10:30 AM, Dietary Manager E verified the ice machine drain pipe had no air gap and touched the inside of the floor drain.	F 371		

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F 371	Continued From page 12 On 3/23/15 at 10:20 AM, Administrative Staff A verified the maintenance staff had raised the drain pipe so it was no longer touching the soiled floor drain. The facility's July 2006 cleaning instructions for ice bins directed the staff to mix a solution of sanitizer and thoroughly wash all interior surfaces of the ice storage bin and then pour the excess sanitizer solution into the bins drain. The document lacked instructions for proper sanitary drainage. The facility failed to ensure the ice machine drainage system had a 2 inch air gap in the system for infection control purposes for the 50 residents residing in the facility.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This Requirement is not met as evidenced by: The facility had a census of 50 residents. The sample included 14 residents, of which 5 were reviewed for medication regimen. Based on observation, interview and record review the facility's pharmacist consultant failed to identify and address, in a timely manner, 2 of 5 sampled	F 428		

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residents who received the maximum dose of scheduled Tylenol. (#7, #36)

Findings included:

- Resident #7's annual (MDS) Minimum Data Set assessment, dated 11/10/14, indicated the resident alert and oriented with a (BIMS) Brief Interview for Mental Status score of 15, and independent to limited assistance with (ADLs) Activities of Daily Living. The MDS indicated the resident received scheduled pain medications, reported no pain, and received antipsychotic, antidepressive and diuretic medications 7 days of the look back period. The quarterly MDS, dated 2/8/15, indicated the same.

The 11/11/14 (CAA) Care Area Assessment summary for medication use directed the staff to administer medications as ordered, educate the resident of the risks of refusing medication, observe for oversedation, and notify the physician if needed.

The 2/16/15 care plan directed the staff to administer medications as ordered, educate the resident of the risks of refusing medication, observe for oversedation, and notify the physician if needed.

The 3/5/15 physician's order sheet directed the staff to administer Tylenol, 1000 (mg) milligrams, 4 times daily, to the resident, initiated 9/25/07.

The 3/17/15 pharmacist consultant document recommended a dose reduction or risk versus benefit statement for the continued use of 4000 mg of Tylenol, daily. Review of the monthly pharmacist recommendations to the Director of Nursing for the past 15 months, revealed no

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concerns regarding the amount of Tylenol the resident received (4000 mg, daily) until 3/17/15, when he/she recommended a dose reduction.

On 3/18/15 at 11:55 AM, the resident stood patiently in line for his/her medication, took medications with water and had no problems.

On 3/19/15 at 8:50 AM, Nurse G stated the resident does not complain of pain. Nurse G stated he/she had not been aware of any dosage limitations for Tylenol until the pharmacist was here 2 days ago and recommended a decrease in the resident's dosage. Nurse G stated the physician had ordered the decrease.

On 3/17/15 at 3:55 PM, Administrative Nurse B stated the resident has received Tylenol, 4000 mg, daily, for a long time. He/she verified the resident's physician had not changed the dosage of Tylenol since 2007.

The (FDA) Food and Drug Administration web site, fda.gov, stated manufacturers must use specific language referring to Tylenol's maximum dosage in term of dosage units, or total number of tablets that should not be exceeded in a 24 hour period. The FDA stated the label had to read "Severe liver damage may occur if you take more than 8 (500 mg) tablets, for a total of 4000 mg, in 24 hours", which is the maximum daily amount for Tylenol.

The facility pharmacist consultant failed to identify and address Resident #7's continued use of the maximum dosage of Tylenol, putting the resident at risk for liver damage from the excessive, long term dosage.

- Resident #36's annual (MDS) Minimum Data

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	17E210	A. BUILDING _____ B. WING _____	03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW MANOR OF PEABODY	500 PEABODY PEABODY, KS 66866

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Set assessment, dated 10/20/14, indicated the resident alert and oriented with a (BIMS) Brief Interview for Mental Status score of 15, and independent with (ADLs) Activities of Daily Living. The MDS indicated the resident received scheduled pain medications, reported no pain and received antipsychotic, antianxiety, antidepressive and diuretic medications 7 days of the look back period. The quarterly MDS, dated 1/18/15, indicated the same except frequent moderate pain.

The 10/20/14 (CAA) Care Area Assessment summary for medication indicated nursing to administer medications as ordered and observe for oversedation.

The 1/26/15 care plan for pain directed staff to encourage the resident to describe his/her pain and location, administer medications as ordered, evaluate effectiveness of pain medications, and notify the physician as needed.

The 3/5/15 physician's orders directed staff to administer Tylenol, 1000 (mg) milligrams, 4 times daily, initiated 10/12/10.

The 1/27/15 physician's note stated the resident's pain in his/her hip was well controlled and the resident was managing well with scheduled Tylenol.

Review of the monthly pharmacist recommendations to the Director of Nursing for the past 15 months, revealed no concerns regarding the amount of Tylenol the resident received (4000 mg, daily) until 3/17/15, when he/she recommended a dose reduction.

The 3/17/15 pharmacist consultant document

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F 428	Continued From page 16 recommended a dose reduction or risk versus benefit statement for the continued use of 4000 mg of Tylenol, daily. On 3/18/15 at 11:01 AM, observation revealed the resident took his/her medications and stretched his/her neck upward while swallowing. On 3/19/15 at 8:50 AM, Nurse G stated the resident does not complain of pain. Nurse G stated he/she had not been aware of any dosage limitations for Tylenol until the pharmacist was here 2 days ago and recommended a decrease in the resident's dosage. Nurse G stated the physician had ordered a dose reduction. On 3/17/15 at 3:55 PM, Administrative Nurse B stated the resident had received Tylenol, 4000 mg, daily, for a long time. He/she verified the resident's physician had not changed the dosage of Tylenol since 2010. The (FDA) Food and Drug Administration web site, fda.gov, stated currently manufacturers must use specific language referring to Tylenol's maximum dosage in term of dosage units, or total number of tablets that should not be exceeded in a 24 hour period. The FDA stated the label had to read "Severe liver damage may occur if you take more than 8 (500 mg) tablets, for a total of 4000 mg, in 24 hours", which is the maximum daily amount for Tylenol. The facility's pharmacist consultant failed to identify and address Resident #36's continued use of the maximum dosage of Tylenol, putting the resident at risk for liver damage from the excessive, long term dosage.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 17 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This Requirement is not met as evidenced by: The facility had a census of 50 residents. The sample included 14 residents. Based on observation, record review and interview the facility failed to ensure appropriate labeling of an	F 431		

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F 431	Continued From page 18 insulin pen in 1 of 1 medication rooms for 1 of 3 insulin dependent residents. (#26) Findings included: - On 3/16/15 at 8:35 AM, during the initial tour, observation revealed the medication room had 1 Levemir insulin pen, not dated when opened. Nurse C verified the insulin pen was not dated during the observation. The 8/17/13 physician's order for Resident #26's Levemir Insulin Pen instructed the staff to administer Levemir 25 units (sq) subcutaneous (beneath the skin) at hour of sleep. On 3/19/15 at 1:15 PM, Administrative Nurse B stated the nurses knew to date the Insulin Pens or the Insulin Vials when opened. The 4/2007 facility Insulin Administration policy instructed, when opening a new vial of insulin, record the expiration date and time on the vial or pen. The facility failed to ensure the staff labeled Resident #26's Levemir insulin pen appropriately to ensure the stability of the medication.	F 431		